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To: Nursing Homes NH-43

From: LaVern Woodford, Chief
Bureau of Quality Assurance, Resident Care Review Section

cc: Susan Schroeder, Director
Bureau of Quality Assurance

Immediate Jeopardy Citations

We have seen an increase in the number of immediate jeopardy citations in Wisconsin this year. As of today, the Bureau of Quality Assurance (BQA) has issued 27 citations at the level of immediate jeopardy. This compares to two immediate jeopardy citations in 1997, eight in 1998, and twelve in 1999. In this memo, we highlight the types of situations that are being cited at the level of immediate jeopardy. We hope that you will look at your facility's practices to ensure that these types of practices do not occur.

Immediate jeopardy is a crisis situation. It occurs whenever noncompliance with a federal regulation:

- has caused, or is likely to cause, serious injury, serious harm, serious impairment, or death to a resident;
- there was, or is, a likelihood for serious harm to occur to the resident or to other residents at the facility;
- immediate corrective action is, or was, needed to prevent serious harm from occurring.

An immediate jeopardy situation that exists at the time of the survey must be abated within 23 days from the date of the exit conference or a facility faces termination from the Medicare and/or Medicaid program(s). Once steps have been taken to reduce the immediacy for serious harm, a nursing home must still correct the underlying systems problem(s) that led to the deficient practice.

The majority of immediate jeopardy citations in Wisconsin this year have fallen into the following six categories:

- *Inappropriate action following a significant condition change in a resident (5).* These immediate jeopardy citations involved incidents where residents had significant changes in their physical conditions (e.g., temperature above 104 degrees; temperature of 93 degrees accompanied by labored breathing and mottling of the legs; complaints of chest pain accompanied by shortness of breath and agitation and repeated requests to see the physician; shortness of breath, anxiety, and resident statements of "not wanting to die.") In all these cases there was not a prompt RN assessment and either no contact, or an untimely contact, with the physician. These situations could have been avoided had staff promptly notified the charge nurse of the condition change or if licensed nurses had

promptly assessed the resident when notified of the condition change, recognized the seriousness of the condition change, and taken appropriate follow-up action based on an accurate assessment.

- *Resident wandering (5).* In most of these situations, residents with a known history of wandering set off the facility's alarms and eloped from the facility. Staff either did not respond to the alarms or responded by taking a quick glance outside and then resetting the alarm. These residents were outside, inappropriately dressed in bad weather conditions or were found along busy highways. These situations could have been avoided had staff responded promptly to the alarm, done a thorough check around the entire building after the alarm went off, and checked to see if all residents identified as having wandering behavior were accounted for after finding no resident outside.

- *Restraints (4).* In these situations, restraints were either inappropriately applied and residents had slid down and had the restraint around their neck, or residents had become trapped in the gap that existed between the mattress and the siderail. Facility staff had not assessed these situations to ensure that these life-threatening situations would not reoccur or could not occur with other residents. These situations could have been avoided had staff thoroughly assessed the situation when it occurred, recognized the danger of the situation, and developed alternate approaches to reduce the risk for strangulation. Where gaps existed between the side rail and the mattress, immediate jeopardy may have been avoided if staff had assessed other residents having the same type of mattress and side rail and taken appropriate steps to reduce their risk for harm.

- *Inappropriate feeding techniques for residents at high risk for aspiration (3).* Generally, these citations involved residents who were at high risk for aspirating and who had specific recommendations and/or care plans for feeding. Surveyors observed staff feeding these residents contrary to specific recommendations for them or to their care plans (e.g., feeding at a rapid pace, not positioning the resident correctly, not cueing the resident, and/or serving foods that were not thickened to meet the ordered consistency). These situations could have been avoided if staff who were feeding the residents had been aware of their dietary/feeding needs and been following the identified approaches.

- *Resident-to-resident abuse (2).* These citations involved residents with a pattern of physically or sexually assaulting other residents. Facility staff had not taken appropriate proactive precautions to ensure the safety of residents on the unit, but, instead, relied on redirecting the resident or keeping the resident separated from those who had already been victimized. These situations could have been avoided had staff developed and implemented ongoing proactive approaches to modify the environment to help reduce the number of opportunities for resident-to-resident altercations to occur rather than reactive approaches to separate the residents when altercations occurred.

- *Resident falls (2).* These citations involved residents with a history of repeated falls. The residents knew how to disarm the personal alarm and would attempt to ambulate without staff knowledge. At other times, these residents would set off the alarm but staff did not respond promptly to it. Despite the repeated falls by these residents, and in some

cases, repeated injuries, staff continued to rely on the alarms without attempting other interventions or without increasing staffing so that staff could promptly respond to alarms. In these situations, we did not cite immediate jeopardy because the residents fell. Reducing restraints means that falls will occur. We cited immediate jeopardy because staff were not assessing the falls, reacting to the number of falls, and working to identify what other approaches might be implemented to reduce the number of falls, given that the current approaches were not effective.

We also have cited immediate jeopardy at:

- F353, because staffing was not adequate to meet the needs of residents; and at
- F490, because the administrator had not ensured that facility resources were being used effectively to help residents attain their highest level of functioning and well being.

Please review this information with your staff to ensure that facility practices in these areas protect residents and will neither lead to a citation nor to a citation at the level of immediate jeopardy. If you have questions, please contact your Regional Field Operations Director at the address and phone number below.

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